TITLE V TOOL MONITORING INSTRUCTIONS
FY 2007

Reviews are based on requirements found in the Policy Manuals. These instructions highlight review procedures. Please note that the manuals should always be referred to as the complete reference.

REVIEW CRITERIA	INSTRUCTIONS
I. Eligibility	Ten (10) records are reviewed. If the agency provides services at several sites, 10 records with a sampling from all services are reviewed at each of the sites visited by the Quality Management team. When possible, three (3) of the records should be of clients who have been or are currently on presumptive eligibility. The reviewer selects the records to be reviewed from monthly billing logs (or Compass 21 for Title V Family Planning) over a period of several months. If a record is not available, select another record for review and inform the team leader so a determination can be made regarding how to mark this section. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. **NOTE THE FOLLOWING EXCEPTIONS THAT ARE AUTOMATIC FINDINGS: (1) an eligibility finding resulting in the client's actual ineligibility; (2) overcharging the client for covered services; and (3) billing for services not documented in the client's record.** If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. Ten (10) records are reviewed at each site visited. The 80% compliance level is applied per site visited. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader will be notified.
1. The agency is utilizing an approved screening and eligibility tool.	The reviewer examines client records for an approved and complete screening/eligibility tool. An approved screening and eligibility tool includes: 1. The Screening and Eligibility Determination Form for Medical Services Assistance

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	2. DSHS approved agency screening/eligibility form (proof of approval must be available for the QMB Team to review) The reviewer examines the policy and procedure outlining the process for verifying family composition, residency and/or income. The reviewer examines the client records for: 1. A completed Eligibility Determination Form that includes accurate income calculations. The reviewer checks each record for accuracy in the calculation of the client's income based on the current Federal Poverty Level (FPL) and criteria set forth in the Policy Manual. If actual or projected income is not received monthly, it is converted to a monthly amount using one of the following methods: i. weekly income x 4.33 ii. every two weeks x 2.17 iii. twice a month x 2 See the Policy Manual for self-employment income and other special benefits and exemptions. ***A "No" finding is given if the inaccurate calculation would result in ineligibility.** 2. Supporting documentation for family composition, residence and income 3. Consistent application of agency eligibility policy 4. Medicaid/CHIP denial letters 5. Updating eligibility when family composition, residence, or income change 6. Annual re-certification **Note: The option not to request documentation of family composition, family member Texas residency status, and income are not available for use by PHC as they are for Title V.** If client self discloses pertinent information that will make them ineligible, then no referral to Medicaid or CHIP will be required, but this fact should be documented in the client's record. If the county has additional requirements, which would deny eligibility for County Indigent Health Care Program (CIHCP) this may be documented and the client not referred. Clients waiting

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	for enrollment into CHIP need to have the enrollment date verification form in the chart. **NOTE: Contractors are allowed to continue providing funded services after the initial 90-day period ONLY if the client has applied for CHIP and is waiting on approval, and until the date CHIP enrollment is effective.** ***A "No" finding is given for incomplete items or miscalculation of income that can result in an incorrect determination of eligibility or if the process is done incorrectly or not done.** **(Refer to I.1. of the Eligibility and Billing record review tool).**
2. Presumptive eligibility form is completed prior to receipt of services.	The reviewer checks to see that the "Presumptive Eligibility" is completed under appropriate circumstances and as detailed in the Title V Policy Manuals. **(Refer to I.2. of the Eligibility and Billing record review tool).**
3. A current Statement of Applicant's Rights and Responsibilities Form has been completed/signed/dated by all categories of client and by agency staff.	The reviewer checks each client record for a completed/signed/dated Statement of Applicant's Rights and Responsibilities Form. Completion of the Statement of Applicant's Rights and Responsibilities Form is required for presumptive eligibility. **Note:** The form only needs to be re-signed in the event of a 2-year break in service. **(Refer to I.4. of the Eligibility and Billing record review tool).**
II. Billing	**The same records reviewed for eligibility are reviewed for billing.**
1. Monthly logs/encounter forms of services billed to Title V are maintained.	The agency maintains monthly logs/encounter forms of services billed to Title V MCH and Dysplasia which detail the date and type of service provided. **Note: This is not applicable to Title V FP as services are captured in the Compass 21 claims processing system.**
2. Revenue collected as co-payment from a client whose services are reimbursed with Title V funds must be identified and reported as program income on the Monthly Reimbursement Request form for the same month for MCH and Dysplasia.	The reviewer requests the contractor to provide their method of tracking co-pays and compares it to the same month's submission of the Monthly Reimbursement Request for MCH and Dysplasia. The contractor may use a monthly log to document co-payments received for MCH and Dysplasia services. **Note: This is not applicable to Title V FP as services are captured in the Compass 21 claims processing system.**

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3. Title V billing review:	The reviewer selects ten (10) records from across all Title V services using the agency monthly Title V billing log to select Maternal, Dysplasia, and Child Health records and Compass 21 to select Family Planning records.
a. Clients at or below 100% of FPL are not charged a co-pay for Title V services, as required by Federal law.	Under Title V Federal Regulations, clients who are at or below 100% of FPL must not be charged a co-pay for Title V services. The reviewer checks the client record to verify adherence to this policy. **(Refer to II.1. of the Eligibility and Billing record review tool).**
b. If a co-pay fee is charged for clients between 101-185% of the FPL, it is consistently applied according to the agency's policy.	The agency has a written co-pay fee scale established on current Federal Poverty Level allowing co-pay charges up to 25% of the reimbursable amount of the service provided for clients between 101% to 185%. The reviewer checks the client record to verify adherence to this policy and that client was not charged for reimbursable services. **Note: The contractor must waive co-payment if a client self declares an inability to pay. (Refer to II.2. of the Eligibility and Billing record review tool).**
c. Billing is for an allowable service, is supported by documentation in the client record and matches the Title V billing log/encounter forms for MCH and Dysplasia services and Compass 21 claims for Family Planning services.	The reviewer compares service date documentation in the client record to verify that it matches the service date in the Title V billing log/encounter forms for MCH and Dysplasia services and Compass 21 claims for Family Planning services and that the client is eligible for services prior to the delivery of services. The reviewer compares client services documented in the client record to verify that the services match the billed services in the Title V billing log/encounter forms and Compass 21. **(Refer to II.3. of the Eligibility and Billing record review tool).**
III. Family Planning Criteria	The following criteria is applicable to contractors who provide Title V Family Planning services
1. The following contraceptive methods are provided on-site:	The agency makes available on-site a broad range of reversible contraceptive methods, including methods from each of the categories below. All methods need not be present at each clinic within the agency; however, there must be a method of obtaining the contraceptive method from another clinic within the agency. The reviewer interviews agency staff and/or views inventory to assure the availability of the following contraceptive methods:
a. Sexual abstinence counseling	The agency provides counseling on sexual abstinence.
b. Barrier method and spermicide	The agency provides male condoms and at least one female barrier method (female condom, foam, diaphragm, cervical cap, contraceptive sponge, Lea's shield or Femcap),) and one spermicidal method (gel, cream, foam,

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	suppositories, N-9 film) on site.
c. Hormonal methods	The agency provides at least one combined oral contraceptive monophasic formulation (Alesse, Mircette, Seasonale, Noredette); one combined oral contraceptive multiphasic formulation (Ortho Tri-Cyclen, Cyclessa, Jenest); one progestin only oral contraceptive (Micronor, Ovrette, Nor-QD); injectable hormonal contraceptive (Depo-Provera); transdermal hormonal contraceptive (Ortho Evra) and/or vaginal hormonal contraceptive (Nuva Ring); and emergency contraceptive pills (2 tablets of 750 mcg levonorgestrel, combined estrogen-progestin ECP options) on site.
2. The following contraceptive methods are provided on site-or by referral	
a. IUDs	The agency provides at least one type of intrauterine device or system, such as the copper-T IUD (ParaGard) or the levonorgestrel intrauterine system (Mirena).
b. Fertility awareness	The agency provides education to teach clients how to determine the beginning and end of the fertile time during the menstrual cycle potentially using one or more of these indicators: calendar calculations, cycle beads, basal body temperature, or cervical secretions.
c. Sterilization (both male and female)	The agency provides or refers clients for male and female sterilization procedures. (**Note:** The contractor's proposal indicates the number of sterilizations to be performed annually.)

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IV. Clinical Record Review	Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. Ten (10) records from each service (family planning, prenatal, child health, and dysplasia) provided by the agency are reviewed. The same records used for the billing and eligibility portion of the review may be used and additional records selected using the agency monthly Title V billing log to select Maternal, Dysplasia, and Child Health records and Compass 21 to select Family Planning records. The 80% compliance level is applied per site visited. If multiple sites are visited during a review, ten (10) records from each service provided at each site visited are reviewed. In the case where a record is not available for review, select another record and inform the team leader. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader is notified. Related to Title V Child Health, all components (unless medically contraindicated) must be completed and documented for the visit to be considered a Title V comprehensive well child medical checkup. The provider is expected to attempt to schedule and provide routine well child preventive health examinations in addition to the sick child office visits.
1. Consent forms (to include Method specific and HIV consent forms, if applicable) are completed and signed.	The record contains the following consents: 1. General Consent for treatment (**NOTE:** Minors may consent to their care related to pregnancy including a pregnancy test. **Scored on the Core Tool)** 2. Method Specific Consent for prescription method of contraception, if applicable, for Family Planning services (**NOTE:** Minors may consent for Family Planning services provided under Title X only, Title X/XX or Title XIX) 3. HIV consent given verbally or in writing is documented, if

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	applicable (NOTE: Minors may consent to HIV/STD screening and testing) 4. Sterilization Consent Form, if applicable
2. History (initial and interval as appropriate) is completed to include allergies, a risk assessment/identification (family violence, TB, lead, etc.) and immunization status.	The record contains the following information as appropriate to the client: 1. Reason for visit 2. Current health status, including acute and chronic medical conditions **(not required for Dysplasia services)** 3. Significant past illness, including hospitalizations 4. Previous surgery/biopsies 5. Blood transfusions and other exposure to blood products **(not required for Dysplasia services)** 6. Current medications, including over the counter and alternative medications 7. Allergies, sensitivities or reactions to medicines or other substance(s) 8. Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route) 9. Immunization status, including rubella status (non-pregnant female clients of childbearing age with unknown or inadequate rubella immunity must be provided vaccination on-site or referred) **(not required for Dysplasia services)** 10. Pertinent history of immediate family **(not required for Dysplasia services)** 11. Assessment of family violence (including safety assessment, if indicated) **(not required for Dysplasia services)** 12. Partner history (including injectable drug use, number of partners, STDs and HIV history and risk factors, and bisexuality) 13. Reproductive health history a. Sexual behavior history, including family planning practices, number of partners, sexual orientation, sexual abuse b. STDs (including hepatitis B and C) and HIV risks and exposure c. Urologic conditions d. Additional *female* reproductive health history elements include:

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	i. Menstrual history ii. Obstetrical history iii. Gynecological conditions iv. Cervical cancer screening history v. In utero exposure to diethylstilbestrol (DES) Additionally, a maternity client's interval history includes: 1. For return prenatal visits: a. Symptoms of infection b. Symptoms of preterm labor c. Headaches or visual changes d. Fetal movement (>18 weeks) e. Family violence screening (>28 weeks) 2. For postpartum visits: a. Labor and delivery history with maternal and neonatal complications b. Infant bonding c. Breast feeding/infant feeding issues d. Symptoms of infection e. Symptoms of excessive/abnormal vaginal bleeding f. Assessment of postpartum depression Additionally, a child's/adolescent's health history includes: 1. Neonatal (inpatient to 2 weeks of age), as indicated 2. Mental health history 3. Developmental history 4. Nutrition and feeding problems history 5. Risk factors for lead, TB, hyperlipidemia/cholesterol (a Risk Assessment for Lead Exposure Questionnaires (E/S) is available in the TMPPM for well child visits through 6 years of age and TB risk assessment forms are also available in the TMPPM for reference) Applicable interval histories are obtained.
3. Physical and developmental assessments are documented.	The record documents a complete physical assessment as applicable, including: 1. Height measurement (children, adolescents and annually for females 20 years of age or younger until 2 years post menarche and females 55 years of age or older) 2. Weight measurement (for maternity clients note pre-pregnancy

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	weight and assess on return prenatal and postpartum visits) 3. Blood Pressure evaluation (ages 3 and older; reassess on return prenatal and postpartum visits) 4. Cardiovascular assessment 5. Clinical Breast exam for females 20 years of age and older (reassess on postpartum visit) 6. Visual inspection of external genitalia and rectum 7. Pelvic exam, including vulvar evaluation and bimanual exam for females (including sexually active adolescents; reassess on postpartum visit) 8. Palpation of prostate for males as indicated by history 9. Manual examination of penis, scrotum, and testicles for males 10. Other systems as indicated by history, risk profile, other findings Additional assessments for maternity clients include: 1. Uterine size for gestational age </= 14 weeks or fundal height for gestational age >/= 14 weeks; and on postpartum visit 2. Fetal heart rate (> 12 weeks) 3. Fetal lie/position (> 30 weeks) Additional assessments for children and adolescents include: 1. General head-to-toe exam appropriate to the purpose of the visit. For any portion of the examination that is deferred, the reason(s) for deferral is documented in the client record. 2. BMI (clients 2-20 years of age) 3. Fronto-occipital head circumference (2 years of age and under) 4. Nutritional assessment (Refer to Guidelines for Nutrition Assessment for more information) 5. Developmental assessment 6. Mental health assessment 7. Vision and hearing screening appropriate to age (more information on vision and hearing screening may be found in Texas Medicaid Provider Procedures Manual (TMPPM), Texas Health Steps) 8. Age appropriate immunizations 9. Dental assessment **NOTE: Dysplasia visits include a problem-focused physical exam including:** 1. Weight measurement

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	2. Blood pressure evaluation 3. Visual inspection of external genitalia and rectum 4. Pelvic exam, including vulvar evaluation 5. Colposcopy with or without biopsies as indicated
4. Appropriate lab/diagnostic tests are ordered, tracked, results reviewed, and the client was notified of abnormal findings.	The record contains documentation that lab/diagnostic tests were ordered and tracked, the results were reviewed, and the client was notified of abnormal findings. **For Dysplasia clients Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities are followed).** Laboratory tests, based on risk assessment, history, or physical exam for Family Planning and Prenatal clients include: 1. Cervical cancer screening (may be delayed until three years after sexual debut or at age 21 years, whichever comes first or with documented normal results of a pap smear done within previous 12 months or clients with vaginal bleeding or friable cervix) (**Note:** Conventional Pap tests should be performed annually, then every 3 years for women age 30 years or older once 3 consecutive negative cytology tests are achieved. Liquid-based cytology should be performed every 2 years, then every 3 years for women age 30 years or older once 3 negative cytology tests are achieved.) 2. Sexually transmitted disease testing (including Syphilis serology, Hepatitis B Antigen (HbsAg), HIV, Gonorrhea, Chlamydia) should be provided for the determination of health status and/or diagnostic purposes, if indicated. (Chlamydia testing is recommended for sexually active females age 24 or younger at least annually based on risk assessment.) 3. Pregnancy test 4. Rubella serology, if status not previously established 5. TB skin test 6. Other lab/diagnostic test <u>Additional</u> laboratory tests for Prenatal clients include: 1. Blood type, Rh and antibody screen 2. Hgb/Hct at initial visit (recommended recheck at 32-36 weeks) 3. Hemoglobinopathy screening, as indicated 4. Urine screen or culture 5. Ultrasound, only as clinically indicated

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	6. Maternal Serum alpha-fetoprotein testing or multiple marker serum screening when indicated and elected by client (15-20 weeks) 7. Prenatal fetal screening/diagnosis, offered to clients age >/= 35, or otherwise at increased risk for trisomy 21 or other fetal genetic disorders (e.g. chorionic villus sampling at 10-12 weeks or amniocentesis at 15-18 weeks) 8. Diabetes screen (24-28 weeks) and Glucose Tolerance test for abnormal screen 9. Antibody screen for RH negative clients, not previously known to be sensitized, between 24-28 weeks (to assess need for Anti-D immune globulin to be given at approximately 28 weeks) 10. Group B Streptococcus screen (between 35-37 weeks) 11. Non-stress Test (NST) to assess fetal well-being, as clinically indicated 12. Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP) with Non-Stress Test to assess fetal well-being, as clinically indicated Laboratory tests for children and adolescents include: 1. Newborn Hereditary/Metabolic Testing (NBS) up to 12 months of age (Newborn screening (hereditary/metabolic testing hypothyroidism, PKU, galactosemia, sickle Hgb, and CAH) is required by Texas law before hospital discharge and again between 1 and 2 weeks of age. Date and results of the second newborn screening are to be documented. NBS results may be available from the DSHS Lab by calling 512-458-7578.) 2. Hgb/hct (testing results from WIC clinic or other providers are acceptable if completed within one month of visit). (A Hgb may be used as a screen for iron deficiency anemia for menstruating, non-pregnant adolescent females according to risk and history) 3. Hemoglobin Type as indicated when a disorder associated with abnormal forms of hemoglobin (hemoglobinopathy) is suspected. Hgb type results may be available from the DSHS Lab by calling 512-458-7578 4. Urinalysis as indicated 5. Lead blood testing as indicated by risk assessment and physical exam 6. Hepatitis C testing if 12 months of age and older if mother is

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	Hepatitis C positive 7. Cholesterol screening based on family history, as indicated by risk assessment 8. Sexually transmitted disease testing as described above under Family Planning if indicated by risk assessment (age 11 and older) 9. Cervical cancer screening test (Pap Smear) as described above under Family Planning 10. TB skin test as indicated 11. Other labs as indicated
5. Education/counseling/anticipatory guidance is documented, as appropriate.	The record contains documentation of client-centered education and counseling based on health history, risk assessment, and physical history, including: 1. Family Planning: a. Initial Education including: i. Making informed family planning decisions ii. Being aware of available contraceptive methods, including benefits and efficacy iii. Reducing risks of STD's and HIV ➢ Discussion about personal risks ➢ Risk reduction and infection prevention information addressing sexual abstinence, mutual monogamy with an uninfected partner, and/or condom use iv. Understanding the range of services available and how to access specific services v. Understanding the importance of recommended screening tests, health promotion and disease prevention strategies (i.e., cervical cancer screening, colo-rectal cancer screening, smoking cessation, proper diet or physical activity) vi. Performing breast or testicular self-examination b. Method Specific Counseling including: i. Results of physical exam and evaluation ii. Correct use of client's selected method of contraception including side effects and

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	complications iii. Back up methods, including emergency contraception and discontinuation issues iv. Scheduled revisits v. Access for urgent and emergency care, including 24-hour emergency telephone number vi. Appropriate referral for additional services as needed 2. Prenatal - Information on the following legislative mandates may be provided at anytime during prenatal, delivery, or postpartum services and must be documented: a. Child immunization schedule b. Newborn screening including appropriate schedule for follow-up procedures c. Postpartum depression resource list d. Shaken baby syndrome and coping techniques e. Initial prenatal visit i. Nutrition and weight gain counseling ii. Family violence/abuse iii. Physical activity and exercise iv. Sexual activity v. Environmental or work hazards vi. Travel vii. Tobacco viii. Alcohol use ix. Substance abuse x. Breastfeeding xi. When and where to obtain emergency care xii. Risk factors identified during visit xiii. Anticipated course of prenatal care xiv. HIV and other prenatal test xv. Seat belt use xvi. Toxoplasmosis precautions xvii. Referral to WIC xviii. Use of medications

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	xix. Information on parenting and postpartum counseling f. Return prenatal visits i. Signs and symptoms of preterm labor (beginning 2nd trimester) ii. Warning signs and symptoms of pregnancy induced hypertension iii. Selecting provider for infant iv. Postpartum family planning g. Postpartum i. Physiologic changes ii. Signs and symptoms of common complications iii. Care of breast, perineum and abdominal incision iv. Physical activity and exercise v. Breastfeeding/Infant feeding vi. Resumption of sexual activity vii. Family planning/contraception viii. Preconception counseling ix. Depression/postpartum depression 3. Dysplasia a. Sexual activity b. Tobacco c. Alcohol use d. Substance abuse e. Risk factors identified during visit 4. Child/Adolescent Health Initial Well Visit (must be face-to-face with the child's parent/caretaker and face-to-face with adolescents*): a. Anticipatory guidance including injury prevention, behavior, health promotion and nutrition b. Child development c. Immunizations d. When and where to obtain emergency care e. Risk factors identified during visit f. Referral to WIC

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	g. Information on parenting and postpartum counseling (mandated) Other education and counseling is provided as indicated by risk assessment, history and physical exam * Standard of practice but do not score "No" if not done.
6. Problem management/treatment.	The record contains documentation that problems were managed or treated.
7. Referrals as indicated.	The record contains documentation of referrals, as applicable, including the provision of pertinent client information to the referral source in compliance with HIPAA regulations. For Child Health, dental referrals are given for all patients beginning at 1 year of age.
8. Follow-up to include return visit date, missed appointments, and referral outcome.	The record contains documentation of follow-up, including, preventative physical exam, the return visit date, missed appointments, and referral outcome, as appropriate. If a child comes under care for the first time at any point on the periodicity schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.
Other pertinent information as noted by reviewer.	